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==04/98 (3) The total projected investment from ~~Section 15.c.iv.~~ subsection III.C.7.m.iii.(D). will be multiplied by the following category percentages as applicable, and rates calculated based upon the remaining provisions in ~~15.c.~~ subsectin III.C.7.m.iii.:

(a) Category 1 - 85%
(b) Category 2 - 70%
(c) Category 3 - 55%
(d) Category 4 - 40%

n. Rented facilities will have the capital rates calculated by the same procedures as are used for owned facilities.

07/96 o. Property Taxes

==04/98 i. For 4 and 6 bed ICF/MR facilities which can show they will be required to pay property taxes, ~~the Department~~ DHS/ODD will have the median property tax rate for their geographic area added to the capital rate.

02/92 ii. In subsequent years, the property tax portion of the capital rate will be calculated in accordance with 89 Ill. Adm. Code 140.578(b).

p. Combined Rate

i. Small scale ICF/MR facilities are separately licensed facilities. However, reimbursement for capital costs is based on the sixteen person capacity of a set of four 4-person facilities, or one 4-person plus two 6-person facilities. The set of small facilities used in computing the capital rate will be identified in the provider agreements.

ii. A separate capital rate will be calculated for each licensed facility in the set of four facilities. These rates will be combined to arrive at one average capital rate for the set. The averaging of the capital rates will be weighted according to the number of licensed beds in each of the four facilities in the set.

09/93 q. For the period September 1, 1993, through October 12, 1993, capital rate components shall be set at the level in effect as of June 30, 1993.

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01/94 r. Not withstanding the provisions set forth for reimbursement of long term care services, effective January 18, 1994, reimbursement rates for nursing facilities and ICF/MR facilities will remain at the levels in effect on January 18, 1994, with the following exceptions:

i. Capital rates in effect on January 18, 1994, will be adjusted based on final audits of cost report data.

ii. Capital rates will be increased for major captial improvements.

07/96 iii. For those for-profit facilities whose fiscal year 1994 capital rate does not include a real estate tax component because it is based upon a non-profit facility's cost report, effective July 1, 1995, the real estate tax component will be added to the capital rate based upon the fiscal year 1994 median real estate tax rate for the geographic area in which the home is located.

==04/98 iv. If a non-profit facility changes ownership on or after July 1, 1995, and the new owner is a for-profit facility, the real estate tax component will be added to the capital rate effective with the change of ownership as recognized by the ~~Illinois Department of Public Health~~ DPH. The real estate tax component will be added at the geographic area median tax rate in effect for the month in which the real estate tax becomes effective.

07/95 v. For those non-profit facilities whose fiscal year 1994 capital rate includes a real estate tax component based upon a for-profit facility's cost report, effective July 1, 1995, the real estate tax component of the capital rate will be removed (unless the non-profit facility rents the home from an unrelated for-profit entity).

==04/98 vi. If a for-profit facility changes ownership on or after July 1, 1995, and the new owner is a non-profit facility, the real estate tax component will be removed from the capital rate effective with the date of change in ownership as recognized by the ~~Illinois Department of Public Health~~ DPH. The real estate tax component will not be removed for a non-profit facility that rents the facility from an unrelated for-profit entity.

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07/96 vii. Effective for services provided on or after July 1, 1996, facilities which are located in an area which has changed geographic designation due to unique labor force factors shall have rates recalculated based upon the ceilings and norms of the newly designated geographic area.

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10/92 D. Reimbursement for Program Costs in Nursing Facilities Providing Psychiatric Rehabilitation Services for Individuals with Mental Illness

==04/98 1. Nursing facilities ~~(ICF and SNF)~~ providing psychiatric rehabilitation services to individuals, excluding state operated facilities for the mentally ill, will be reimbursed for providing a psychiatric rehabilitation services program for each client with mental illness.

10/92 2. Beginning May 25, 1990, facility reimbursement for providing psychiatric rehabilitation services to individuals with mental illness will be made upon conclusion of resident reviews that are conducted by the state's mental health authority or their contracted agent.

==04/98 3. Continued facility reimbursement for psychiatric rehabilitation services program costs is based upon the presence of three (3) determinants. The three determinants will be confirmed and validated during the Inspection of Care (IOC) conducted by ~~Department of Public Health~~ DPH survey staff. The three determinants are:

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a. Minimum Staffing

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i. Direct Services - Facilities must be in compliance with the Health Care Financing Admininstration's (HCFA) (42 CFR 442.201 or 42 CFR 442.302) and the ~~Illinois Department of Public Health's (IDPH)~~ DPH's (Ill. Admin. Code 300, Section 300.1230) minimum staffing standards relative to facility type.

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ii. The amount of direct services staff necessary for delivering adequate psychiatric rehabilitation services programs for individuals with mental illness assumes a full time equivalent (FTE) staff to client ratio of 1:7.5.

b. Qualified Mental Health Professional Services

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i. Each individual's psychiatric rehabilitation services program must be integrated, coordinated and monitored by a Qualified Mental Health Professional (QMHP). Any facility required to provide psychiatric rehabilitation services programs to individuals with mental illness must provide QMHP services at a ratio of one (1) QMHP to thirty (30) individuals being served.

ii. A Qualified Mental Health Professional (QMHP) is a person who has at least one year of experience working directly with persons with mental illness and is one of the following:

(A) A doctor of medicine or osteopathy;

(B) A registered nurse;

(C) An occupational therapist or occupational therapy assistant certified by the American Occupational Therapy Association or other comparable body;

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(D) A psychologist with at least a master's degree in psychology from an accredited school;

(E) A social worker with a bachelor's degree from a college or university or graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body;

(F) A human services professional with at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling and psychology).

c. Assessment and Other Program Services

i. A comprehensive functional assessment that identifies an individual's needs must be performed as needed to supplement any preliminary evaluations conducted prior to admission to a nursing facility.

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ii. Psychiatric rehabilitation services program reimbursement includes other program costs, including program-related supplies, consultants and other items necessary for the delivery of psychiatric rehabilitation services to clients in accordance with their individual program plans.

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iii. Total program add-on reimbursement for delivery of psychiatric rehabilitation services to individuals with mental illness residing in nursing facilities will be ten dollars ($10) per day, per individual being served. Facility eligibility for psychiatric rehabilitation services program reimbursement is dependent upon the facility meeting all criteria.

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E. Exceptional Care

==04/98 ~~The Department~~ DPA may make payments to nursing facilities which meet licensure and certification requirements as may be prescribed by the ~~Department of Public Health~~ DPH and are enrolled in and meet participation requirements of the Medical Assistance Program.

12/95 1. Definition of Exceptional Care in Nursing Facilities

==04/98 Exceptional medical care is defined as the level of medical care with extraordinary costs related to services which include physician, nurse, ancillary specialist services and medical equipment and/or supplies that have been determined to be a medical necessity. This shall apply to Medicaid patients who are being discharged from the hospital or other setting where Medicaid reimbursement is at a rate higher than the exceptional care rate for related services or to persons who are in need of exceptional care services who would otherwise be in an alternative setting at a higher cost to ~~the Department~~ DPA or Medicaid eligible residents transitioning from Medicare to Medicaid while in the nursing facility. This includes, but is not limited to, persons with acquired immune deficiency syndrome (AIDS) or related condition, head-injured persons and ventilator dependent persons.

2. Description of Related Factors Necessary for Admission of Exceptional Care Clients

04/97 a. The nursing facility must agree to all provisions of the agreement. Criteria regarding the provider's ability to provide exceptional care includes, but is not limited to:

==04/98 i. Demonstration of ability to provide specialized nursing care as documented by DPH and DPA records, specifically a minimum of one RN on duty day shift seven days per week. Additional RN staff may be determined necessary by ~~the Department of Public Aid~~ DPA, based on ~~the Department's~~ DPA's review of the individual exceptional care clients' needs. A minimum required number of LPN staff on duty with an RN on call at night; and a respiratory therapist on contract if serving ventilator dependent residents or residents requiring respiratory therapy services;

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ii. Documentation of specialized training and inservicing of all staff caring for exceptional care residents;

04/97 b. Physical plan adaptations to accommodate the necessary equipment, such as an emergency electrical backup system;

i. Appropriate policies and procedures to address the specific needs of the exceptional care resident, including emergency needs;

ii. Valid written agreements for the provision of all necessary medical equipment and supplies, and special services such as respiratory therapy.

c. Information from IDPH and IDPA records will be reviewed and an on-site assessment will be conducted by IDPA Exceptional Care staff as part of determining a facility's ability to provide exceptional care services.

04/97 3. Provider Approval Process and Payment

==04/98 a. A provider shall notify ~~the Department~~ DPA, in writing, of its interest in participating in the Exceptional Care Program.

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==04/98 b. ~~The Department~~ DPA shall negotiate rates with facilities requesting payment for exceptional care services. In determining the rates of payment, ~~the Department~~ DPA shall consider data collected from exceptional care providers during fiscal year 1994, any intervening rate adjustments (including any updates for inflation) and the average cost of each service category for the geographic area in which the facility is located. After approval of negotiated rates, ~~the Department~~ DPA shall annually update a facility's rate for inflation. The rate of payment will be reasonable and adequate to meet the costs incurred by the facilities providing exceptional care. The rate of payment shall not exceed the amount ~~the Department~~ DPA determines would be paid under Medicare principles of reimbursement.

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==04/98 c. In order for a person to be approved for exceptional care placement, the cost of the person's care must be at least 50 percent more than the proposed admitting provider's Medicaid per diem rate (capital, support and nursing components). Computations for determining cost of care shall be based upon costs for services, medical equipment and supplies for the proposed admitting provider as determined by ~~the Department~~ DPA.

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==04/98 d. If approved by ~~the Department~~ DPA, a written exceptional care agreement with the provider shall be executed.

04/97 4. Exceptional Care Monitoring

04/97 a. The provider will maintain separate records regarding costs related to the care of the exceptional care residents.

==04/98 b. ~~The Department~~ DPA shall provide for a program of delegated utilization review and quality assurance. ~~The Department~~ DPA may contract with Medical Peer Review organizations to provide utilization review and quality assurance.

==04/98 c. ~~The Department~~ DPA shall review exceptional care residents' utilization of services every ninety (90) days. A review may be waived by ~~the Department~~ DPA if one or more previous assessments show that a resident's condition has stabilized. However, two consecutive reviews shall not be waived. ~~Department~~ DPA exceptional care staff will maintain contact with the long term care provider regarding the resident's condition during the time period any assessment is waived.

04/97 5. Termination of Exceptional Care Services

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==04/98 a. Providers desiring to discontinue providing exceptional care shall notify ~~the Department~~ DPA, in writing, at least 60 days prior to the date of termination. Payment for exceptional care residents already residing in facilities which notify ~~the Department~~ DPA that they wish to discontinue providing exceptional care services will remain at the previous exceptional care rate as long as the resident meets exceptional care criteria and as long as all related criteria are met by the provider as determined by ~~the Department's~~ DPA's utilization review or the resident is discharged.